1.HealthNet Policy Number: I038-000-120193927-01 2. Authorization Code:

2.Patient Name: MUHAMMAD HAMZA MUNSIF ALI

3.Patient Date of Birth & Sex: 02-04-97(dd/mm/yy) ☑ Male ☐ Female

Mobile No.0547553911

5.Nature of illness or Injury: ☐ Acute ☐ Chronic ☐ Emergency

6.Are You the patient's primary physician: ☐ Yes ☐ No

7.Presenting Complaints:

8.Duration of Symptoms:

9.Onset of Condition:

10.Relevent Past Medical/Surfgical History

DiagonosisiAcute gastritis without bleeding, Vomiting, unspecified, Elevated white blood cell count, unspecified, Fever, unspecified

ICD Code K29.00, R11.10, D72.829, R50.9

12.Etiology:

13.In case of Injury:mode of Injury/place of Injury

14.Plan / Details of Management

a.ProcedureRISEK 40MG,(METOCLOPRAMIDE : 10 MG/2ML) SOLUTION FOR INJECTION,Administered intravenously,CIPROFLOXACIN,Free follow-up consultation of the same diagnosis within 7 days of initial consultation by a General Practitioner.,Intramuscular injection

CPT code0005-174202-0781,0046-150403-1021,96365,30042033,9.1,96372

b.Laboratiry Test:

c.Radiology / Investigations:

15.In Case of Hospitalization: Date of Addmission: Date of Discharge:

16.

PRESCRIPTION WITH DOSAGE & DURATION

Code	Generic	Dosage	Duration	Instructions
0067-116604-0391	(METRONIDAZOLE : 500 MG) FILM COATED TABLETS	FILM COATED TABLETS (20S, BLISTER PACK)	10	Take 1Tablets 2 Time(s) per Day For 10 Day(s) after meal

Code	Generic	Dosage	Duration	Instructions
0054-103201-0391	(CIPROFLOXACIN : 500 MG) FILM COATED TABLETS	FILM COATED TABLETS (10S, BLISTER PACK)	5	Take 1Tablets 2 Time(s) per Day For 5 Day(s) after meal
0252-150407-1171	(METOCLOPRAMIDE : 10 MG) TABLETS	TABLETS (20S, BOX)	7	Take 1Tablets 2 Time(s) per Day For 7 Day(s) before meal

Date: 25-07-24(dd/mm/yy)

Signature and Stamp

Dr. Enomen Goodluck Ekata
General Practitioner
DHA No: 28040827-001
CITICARE MEDICAL CENTER LLC
DUBAI - U.A.E.

Doctor's Name Enomen Goodluck

Physician Code DHA-P-28040827 HNM Code

Authorization

I hereby authorize the Physician, Hospital or Pharmacy to file a claim for medical services on my behalf and I confirm that the above mentioned examination / investigation / therapy is given to me by the doctor. I hereby authorize any Hospital, Physician, Pharmacy or any other person who has provided medical services to me or my dependents to furnish NGI with any and all information with regard to any medical history, medical condition or medical services and copies of all medical and hospital records.

A Photocopy or teletax copy of this authorization shall be considered effective any valid as the original

Date: 25-07-24(dd/mm/yy) Signature of Insued / Claimint

Copy of NGI - Pharmacy

NATIONAL GENERAL INSURANCE CO. (P.J.S.C)

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HealthNet